AZ Medicaid Technical Consortium Meeting

May 5, 2004
2:00 PM to 4:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:
(Based on sign-in sheets)

ADHS	**DES**
Thomas Browning	*Robin Claus*
Lee Cisney	*Marcella Gonzales*
Jerri Gray	*Nicole Yarborough*
Brian Heise	**Healthchoice AZ**
C.J. Major	*Paul Benson*
AHCCCS	*Mike Uchrin*
Howard Beam	**HCSD**
Joe Boyle	*Michael Wells*
Peggy Brown	**MCP & Schaller Anderson**
Deborah Burrell	*Mark Clark*
Barbara Butler	*Cathy Jackson-Smith*
Melonie Carnegie	*Walter Janzen*
Ester Hunt	*Art Schenkman*
Dan Lippert	**PHP**
MaryKay McDaniel	*Robert Imperio*
Brent Ratterree	*Veronika Ramos*
Marna Richmond	**UFC**
Lydia Ruiz	*Kathy Steiner*
Marsha Solomon	*John Valentino*
Carrie Stamos	**United Drugs**
Linda Stubblefield	*Rand Skelton*
Nancy Upchurch	

1. Welcome (Lori Petre)

We are going to go ahead and get started. Everyone should have a package that contains the agenda plus three attachments. Pima County is teleconferenced in for this meeting, and these materials were emailed to them before hand. Brent is going to do a majority of the presentation today, and then MaryKay will walk you through the examples. At any point, ask your questions. We have also left some time at the end for your questions.

2. Pharmacy Layout Crosswalk Review (Brent Ratterree)

There are a couple of things in the packet. One is the proprietary file layout, which is the current pharmacy transaction, which includes the header, detail and the trailer. I am not going to go over this; this is just your reference in case you want to track back to what is happening now. Are there any questions on this?

Q: Is there anything in the NCPDP that is not currently in the proprietary file?
A: Yes. There are also things in the proprietary file that are not in the NCPDP file. It is a reverse mapping.
Lori Petre – We do know that the additional fields that we went through with you, which was the reason for doing this, are not in the current proprietary file. Otherwise, we would have not had to make a change. That is at least one set of things that are not.
Brent Ratterree – The Patient Account Number that we are currently collecting, we are not going to collect. From my standpoint, you can take what we are currently collecting and throw it away. This is something new and different.
Lori Petre – We did take the time to use those specific requests. Once you get an opportunity to look at this, if you have questions, send them to us. We will make sure to respond to them right away.

Q: How do we send negative amounts?
A: I purposely did not show any of the negative or positive signs in here.

Q: Are you going to require the decimal point?
A: Whatever the field description has, that is what we are going to require.

Q: Don't we currently send our claim number as the patient account number?
A: I know there are some contractors that send your claim number in the patient account number field, and some who do not. We are getting rid of the patient account number field completely and capturing a document control number or a similar number that you would use for a health plan claim number. I am going to walk through the document so that we can go over that.

Page 1-7

I am going to walk through this page-by-page, field-by-field. When you get bored, let me know. I am starting out on page 1-7, field 701 from the layout. The first thing that we have is to identify the detail record here as the G1 value. The field IDs are going to correspond to the center transaction itself. The field name is just a description of what that filed is in a generic sense. Encounter usage would show whether it is required or not, and then what the expected encounter value would be. Then we have the field size, which is an indication of what the field size is and the position. If it maps over to the proprietary field ID or name, that will be shown on here as well along with where you would find that information on the current proprietary file. We have a segment in the file, which is G1. Then something called the transaction reference number; the provider will determine this. Whatever that number is that they ship over to you, you will just pass it on through. The BIN number will be on the transaction itself; just pass it on through. The version/release number for this transaction is going to be 3C. The transaction code, which follows, is going to indicate whether it is an original transaction to us, which is a new day never been seen before or you are going to reverse that transaction out or you want to rebill it. It is

essentially the same as we have never seen it before or it is a void or it is a replace, same concept. Processor control number is just something that you would pass on through to us; that is going to be the PBM's number and so forth. Pharmacy number is going to be the AHCCCS pharmacy provider ID and their location code. They are giving that information to us now; you just drop that into the same segment.

Q: Pima Health Plan – Going back to the transaction code, our current methodology at Pima is that when we have to void an encounter, we will send you a reversal, and then we go ahead and make the correction and resend the encounter. Are you saying that in this scenario I would have to send that corrected encounter as a rebill or does the reversal number 11 engage the number 01?
A: You should get a duplicate if you had a number 11 and two 01's. If you submit a rebill 31 or a replacement, then you should not get a duplicate from that.

Q: MaryKay McDaniel - Is the rebill going to automatically void the claim that is out there, and put up this new one?
A: Howard Beam – It is actually saying that it will replace the claim. The system will go out, verify that it is something that can be replaced, and then replace it.

Ideally what you want to do on your replacement logic, if you are going to withdraw an encounter, and then end up replacing it with something else, what you want to do is send in the replacement value. Or in this case, the rebill value because the way the system handles that is that it will create a void out of that; it will do a void and replace for you. In other words, it will back the transaction out, and then correct it. It will actually have three transactions out of one. Where as if you just did a void, and a week or month later a replacement, it is kind of the same thing, but you are making an additional step that you don't really have to unless you want to.

Q: You wouldn't deny it?
A: No, I would not deny it.

Howard Beam – The other advantage to having a replacement or a rebill is that part of the replacement logic is going to build that link so that you can see it.

Q: MaryKay McDaniel – The question, for me, is when you send it in to the health plans, and they send it straight through to AHCCCS, and you have to manipulate that file, how do you make a match on a void?
A: Health Plan - The health plan sends it as a reversal.

Q: MaryKay McDaniel – Do they send you replacements?
A: Health Plan – Yes.

Q: Brent Ratterree - Of course, how often do they have to do a void/replacement or a reversal rebill?
A: Health Plan – A minimum of 10%.

Q: Brent Ratterree – That usually happens within the first 30 days though, right?
A: Health Plan – Yes.

Clarification for Pima Health Plan teleconferenced in. There was a discussion about if there was reversal or rebill that maybe crosses the time period where the health plan would have to file, would the PBM know what the plans claim number would be so that they could just match it.
Pima Health Plan – No, we have to it. It would be difficult for us to follow the sequence of doing a 01 and a 31. Right now, we don't do replacements; we never have.

Brent Ratterree - We are changing our logic as well to accommodate replacements.

Q: Pima Health Plan – So in history, our current methodology is we send the original, and then send a void, and remove it from history, then logically wouldn't it be if we sent you another 01, history would have been deleted, therefore, it would accept the 01?
A: It would do that. We don't actually delete it off the database; we store it behind the scenes. We track everything.

To continue on, the cardholder ID number is going to be the AHCCCS member ID. Send us the date of birth and the sex code. The other coverage code on here is simply asking if they have other coverage and if the other coverage made payment or not.

Q: Are defaults required on fields not used?
A: No, they are not. The preference is spaces.

Page 2-7

On a lot of these codes, for example, customer location, if it is not specified anywhere in the transaction, there is a value for that. If you did not know where the patient's location was, then 00 Not Specified makes the most sense. If there are a lot of fields in here that are unfamiliar or you do not get information on, you can use 00 Not Specified. Eligibility clarification, patient first name, patient last name are not used. Prescription number will be coming from the pharmacy; just pass this through. The new/refill code is currently required so just populate it with whatever the appropriate value is. Metric quantity will not be used. Days supply is a currently required field that you can just pass through. Compound code, will be you don't know, it isn't or it is; use the appropriate value for this field. Most often it is going to be "not a compound code". The NDC number is the last item on this page, and you are currently giving this to us.

Q: Regarding the prescription number, is that going to be 7 digits or 10?
A: I don't expect us to be validating the field size for that.

Page 3-7

The dispense as written field changes; right now it is a 'Y' or 'N'. There are different values that you can transmit to us that will provide us with a little more information as to what is going on at the pharmacy level. Again, if there is no product selection indicated, default to 0. Ingredient cost is the ingredient cost submitted by the pharmacy so you will just pass whatever they are reporting through to us.

Q: If we don't have that ingredient cost, can we just send zeros?
A: No, they have to supply that to us. That is one of the hot topics.

The prescriber ID, which is information that we are getting now, is the AHCCCS provider ID and the location code. The date the prescription is written is the same as the RX order date. The next field is the usual & customary charge is not a required field. If they give it to you, you can pass it through. I do not know how common it is that you will receive that. There is a PA/MC code and number level of service field that is not used. For the diagnosis code, if they give it to you, give it to us. The unit dose indicator, if you know it, give it to us. Otherwise, don't worry about it.

Q: Will the diagnosis code be provided?
A: It is going to be rare that it is provided. We are not going to edit against it; however, if it is reported, it must be a valid diagnosis code.

Page 4-7

The gross amount due, this is the total billed amount from the pharmacy, which should include the ingredient cost and dispensing fee. The other payer amount is the sum of all of the other payer amounts excluding your liability. For example, if you have two other payers on here, you add up those other two payer amounts and report them here. You do not add your paid amount to this field. The patient paid amount, if the pharmacy actually collected money from the individual, we expect to see something greater than zero here. There are a list of fields here, incentive amount submitted, DUR conflict code, DUR intervention code, DUR outcome code; they are not used. The metric decimal quantity is really the quantity dispensed, and that is your units field. There was actually a definition change on the 5.1 to quantity dispensed so that is why this maps over to the units field.

Q: Does this include decimals?
A: Yes, this includes decimals, and it is three decimals. Currently, you cannot report decimals, but with this you will be able to.

There is a field for primary payer denial date. If there is a primary payer involved, and they deny it, you can report it. Ignore the AHCCCS ID field. The resubmission reference number is used if you have to make reversal or rebill. This is where you would drop in the AHCCCS CRN. The PBM unique key and tribe ID are not used. One of the primary reasons for this layout is that some of these fields are used for encounters and some are used for claims. This transaction is a shared transaction by claims and encounters so that is why you will see some of these fields not used where as on the claims side, most of these are going to be used until we get to the encounter specific ones further down. The pregnancy indicator is required; again, either they are pregnant or they or not or it is known. You can leave the value blank if you do not know it. Other fields, which you probably will not see very much of if any, are the other procedure code and the four modifiers along with two additional diagnosis codes. If they report it to you, pass it through.

Q: Does blank mean SV string or do you mean one space?
A: Blank means space.

There is the number of refills authorized; this is a current so you will report the appropriate value there. For claim number, this is where you would report your health plan claim number. If you are tagging it with your claims, then you can report that information here. This one we do expect a value in.

Q: Where is the value 601-68?
A: I can find that for you later. It could possibly be in a transaction above 5.1.

Action Item: Brent Ratterree
Find out where the value 601-68 comes from.

Page 5-7

The unit of measure is a required field. Put in whatever the pharmacy gives you or just pass it through. In the cardholder first name and cardholder last name field, this would be the patient's name. We are not going to be doing any strict editing with this. The next couple of fields, prior authorization type code and prior authorization number, are going to be used, but not right away. They will be used to bypass some of those wonderful medical review edits that we have for encounters. If you do have a prior authorization type code or number, you can report that to us, and some where within the near future, we will be able to bypass those medical review edits. If you do this effective in July 2004, you are not going to be able to bypass that in July, as we are not going to be there for those particular edits. It is on the drawing board. The dispensing fee submitted by the pharmacy, just pass that information on to us. If you are not capturing that now, you need to be capturing it, as this is one of the particularly hot topics. The smoker/non smoker

code can be reported to us if you want, but blank not specified can be used. Then we get into the fun stuff! This is the other payer segment. This first other payer 1 is really you as a health plan. So whatever position you are as a payer, whether it is primary, secondary or tertiary, this is where you are going to put your information. In the other 1 payer ID field, you will put the health plan ID then your 3-byte TSN. A number of these fields are described as amount of payment so you will need to follow the sequence through here. The first field would be your allowed amount. The second one would be the total paid amount, and this would be your paid amount. And then what you paid towards the dispensing fee, the ingredient cost, the co-pay, along with any applicable deductible and co-insurance amounts.

Q: Does the allowed amount include a dispensing fee?
A: I would say yes.

Q: Brent Ratterree - How do you calculate what you are going to pay or do you let the PBM do it?
A: Health Plan – It is the dispensing fee after your other deductions.

Q: Brent Ratterree – In determining your allowed amount, do you have the allowed as dispensing fee, ingredient cost, any other payments or adjustments to that?
A: Health Plan – The allowed is the ingredient cost plus other adjustments.

MaryKay McDaniel – The allowed amount is without the adjustments. It is what they paid for the drug.

Brent Ratterree - If the allowed amount is essentially the ingredient cost allowed, then that is what I expect in the field.

Q: MaryKay McDaniel – So you want to see the ingredient cost in three places?
A: Brent Ratterree - It should be what was submitted, what was paid, and what was allowed. The submitted and paid may not be the same.

Q: Health Plan - What if another payer paid more than what was allowed for that?
A: Brent Ratterree - The allowed amount is going to be your fee schedule. I am not verifying what the other insurances are paying and what your allowed amount is. The only thing you need to consider is that the information for you is accurate and appears to balance out.

Page 6-7

The rest of the layout is pretty simple and very similar. If you have other payers, there is a segment there for other payer 2 and other payer 3. It is the same information in the same sequence. For example, let's say other payer 1 is tertiary. In this sequence, we expect to find the primary payer here, and whatever was allowed like Medicare, and then paid dispensing fee, ingredient cost, etc.

Health Plan – I don't think we will ever know the amount they paid.
Brent Ratterree – You may not, but if you know it, you can pass it through. The one thing that we will absolutely be validating is what they paid. If they report a dispensing fee paid amount and an ingredient cost paid amount, we really need to know that.

Q: If it is secondary or tertiary, it should be reflected on other payer 1 on page 5-7?
A: The payer will always be other payer 1.

Q: What if the other payer is Medicare; what would you put as the ID?
A: Howard Beam – You would put Medicare.

Q: Brent Ratterree – Say there is three payers here; first is Medicare, secondary is Metropolitan. Would you rather see the Metropolitan ID in this field?

A: Howard Beam – The only field that has to be an AHCCCS Provider ID number is the health plan ID.

On the other payer IDs, give us as much information as you have. Make sure that the paid amounts all balance. If you other information, try to make sure it balances in this segment, too. Paid amounts and that sort of thing are very key. There is a large interest in what is going on with pharmacy so the more information you can provide as accurately as possible will help us.

Q: Will the NCPDP 3.2 Layout be emailed to us?
A: Lori Petre – It will be made available on the website.

The header and trailer segments were briefly reviewed.

3. Pharmacy Encounter Examples Review (Brent Ratterree)

G1 Rec Examples 1-3

Let us walk through the thick example first as it is probably the easiest. The top page is the header. On page 1 there are G1 record examples 1-3. We have an original, a rebill and a reversal. The process control number, provider ID did not change, member ID is the same. The voids are the same as the originals. It shows you that it is just a mirror image of the original that was submitted. It was filled on 4/2/04. The other coverage was not specified so you see zeros in that field. It is for a male. On page 2 the location was not specified so you see 00. There is the prescription number. You also see the original fill code of 00 in the New/Refill Code field. This is not a compound code so you see 1 in that field. They originally submitted 015 in the days supply field, but realized it should have been 030. This is a little more of a complicated transaction than we normally see in that there is a replacement of the original and then a void as it was determined that they did not want to pay it after all. The NDC number consists of the Manufacturer's Number, Drug ID and Package Size (MMMMMDDDDPP). The dispense as written, there was not product selection indicated and it is the same across the board. This shows the ingredient cost was $12.73. There is the provider ID and location code for the prescriber ID. In this example, the provider ID is 41753 with location code 18.

Q: What if the prescription was from an out of state doctor?
A: Hopefully, they would have an AHCCCS ID if they are writing prescriptions for the patient.

Q: The physician has to have an AHCCCS ID?
A: Yes, if they want to bill for it.

Lori Petre – Is this a field for editing?
Brent Ratterree - This is a field for editing. In fact, it is a field that we are currently editing.
Lori Petre – Howard, how does this current edit work?
Howard Beam – I believe there is one out there, but I don't know whether it is hard or soft.
Brent Ratterree – The edit is protected; however, I know you have a little logic fix going on for that. It has been protected since 1989. Back to the question, if you can give me some generic percentages of how many of those conditions you have, then we can look at it.
Health Plan – You hit against the pharmacy, not the prescriber ID.
Brent Ratterree - I know that we do have some pends out there for that code. You might be getting some through, but other plans are not.
Howard Beam – I believe the edit is the Z220.

Back to the example. This one just happened to report the usual & customary charge, and there was no diagnosis code. On page 4, the unit dose indicator was not specified so it is 0. Gross billed amount of $17.23; which is right justified. There is no other payer amount.

Health Plan – This is another piece where it conflicts with the 3.2 guide actually says. In order to validate, it makes it so much more difficult.
Brent Ratterree – This is stopgap measurement. We will eventually have to face this, but in the meantime, we have to get this up and running ASAP.

The metric decimal quantity again is here; it is the units 15, 30, 30. The primary payer resubmission reference number you will see on the replacement and void examples. Here is something that is different on the pregnancy indicator. On the original submission it was blank, on the replacement it is not pregnant, and on the void it is blank again. All on the same date of service. The void should have been a 1 as well. There were no modifiers. On page 5, no diagnosis codes. It is 00 for the number of refills. Here is the health plan claim number. The unit of measure was each. Then here is the patient's first and last name. On page 6, the PA type code was listed here as not specified, there is no PA number so it is space filled. The dispensing fee was $3.50. The smoker/non-smoker code was blank. Then for the health plan payment information, which is payer 1, it shows as 01 primary payer. The payer 1 id is the 6-byte health plan id and 3-byte TSN. On page 7, the payer 1 allowed amount in this case $17.23. The payer happened to pay the same as the allowed amount of $17.23. The dispensing fee is at $3.50, the ingredient cost at $12.73, and there was a $1.00 co-pay. There is no other payer. Does this kind of give you an idea about using this transaction?

Q: For the record, the batch number was unique. How are you going to edit against that?
A: I do not plan on editing against that. You might be better off submitting that question to the AHCCCS HIPAA Workgroup email address for an official response so that the people that are actually coding all of the logic can address that.

Q: MaryKay McDaniel – What will the BBA be looking at, the paid amount or the total?
A: Brent Ratterree - Currently, the BBA would be looking for just the file name. Then it would be looking for the claim count and the total billed amount. Not the total claim paid amount. What the other transactions are setup for are file name, claim count and total bill charged. I would expect it to be similar for this transaction as well, but we will be discussing this with the programmers very soon to determine if we are going to do that here as well. We will get that information out to you via email.

Action Item: Brent Ratterree
Email the health plans with the information that the BBA process will be looking at.

GI Rec Examples 4-5

Let us move to examples 4-5. The first example, other payer paid 0, and the second one, the other payer paid $20. The other payer was real nice, and was able to pass us a lot of information. The first two pages will be the same. Let me point out page 3, where they provided a diagnosis code. If you were to have one, this is how you would report it.

Q: Brent Ratterree - Are we going to require the spaces in front of the diagnosis codes or is it just going to be right justified? I think we would get a lot less problems if we were to right justify.
A: Howard Beam – Then we would have to tell them to put in a decimal point.

Brent Ratterree – We can talk about it afterwards, but I think it would be easier to do right justification.
Lori Petre – Yes, if you right justify, you won't have to post the decimal point.
Brent Ratterree – We will talk about placement, but in examples 4-5, it looks like it is right justified.

The gross amount due is the billed amount. On the first one it was $14.29, which was for 30 units. I am going to skip forward. It just so happened that the health plan allowed was $14.29, and you paid $13.05. Let's see what the primary payer did with this.

Q: Brent Ratterree – MaryKay, if the other payer pays $14.29, and you paid $13.05. Let's see what the primary payer did with this.

Q: Brent Ratterree – MaryKay, if the other payer pays zero, shouldn't we indicate on here a zero in the paid amount field for the other payer? Otherwise, if it is space filled, you may not know anything has transpired.
Q: MaryKay McDaniel – Do you want a zero to say they actually paid zero?
A: Howard Beam – Yes, if they actually paid zero.
MaryKay McDaniel – Okay, I will clean it up.

On page 7, the payer 2 paid amount, I am going to put in a zero. Notice they did not give you anything else; all they had was the paid amount of zero. We are back to this other transaction of other payer 1, where $14.29 was allowed, and $13.05 was paid. The ingredient cost and dispensing fee is $13.56. Then in the example where the other payer paid $20.00, the billed amount here was $40.03. The other payer gave you the allowed amount and a paid amount of $20.00. It was processed with a payer 1 allowed amount of $40.03, and paid amount of $20.03. It looks like there was a quick pay discount of $39.53 for that. The ingredient cost is $38.03 and there is only $20.03 left in the balance. You get the ingredient cost and the ingredient cost submitted, and this is the ingredient cost paid. They only have to report on here what they are paying towards the ingredient cost. For example, if the ingredient cost were $100.00, and they were only paying $20.00 on that ingredient cost, then that is what I expect to see on that.

Q: MaryKay McDaniel – Then what is this ingredient cost actually going to be?
A: Brent Ratterree – This ingredient cost for the payment segment is what they paid on that ingredient cost. It is whatever they paid towards that ingredient cost. On page 3, the pharmacy submitted an ingredient cost of $38.03.

Q: If there is some type of discount, where does that come out?
A: Wherever you are taking the discount. I know of one PBM that takes it off the dispensing fee.

Q: Will we get copies of the examples electronically?
A: Lori Petre – Yes, they will be available on the HIPAA website. We will make the corrections prior to posting them to the website with the meeting minutes.

Q: Are the location codes provided by AHCCCS?
A: Yes, AHCCCS provides location codes out on the Provider file. I am not certain how your plans are getting that information to your PBM's now, or if the plans are doing some sort of conversion. I expect that process to continue.

Q: Brent Ratterree – Did these examples help? Did the walk through help.
A: Health Plan – Yes.

Brent Ratterree – If anyone has some real data that we could play with and show as an example, it would be helpful. Of course, for privacy issues we could make it unreal, but I would like to have some real examples so we can show you what you are actually going to see.

4. Questions/Wrap-up (Lori Petre/Brent Ratterree)

Lori Petre – We will get the revised examples out. We will try to get an answer to the BBA issue by this afternoon, and I will email that out. If I cannot get it out this afternoon, it will be first thing tomorrow.

Brent Ratterree - The next Consortium meeting is Wednesday, 5/12/04, from 2:30 p.m. – 4:00 p.m. Thank you, and we will see you next week.

Meeting adjourned.